6300 16<sup>e</sup> Avenue Montréal (Québec) H1X 2S9

Tél.: (514) 864-6464 / 1 800 665-6400

Télécopieur : (514) 864-6400



## REQUEST FOR INCOMPLETE

	STUDE	ENT INFORMATION
Student's 1	ast name:	Permanent code:
Student's f	irst name:	
Address:		
	Street	
	City	
	Postal code	
	STUDEN	VT AUTHORIZATION
any pertine Cégep à di	ent information regarding the status of r	s, hospital representatives or any other organization to provide my health to Cégep à distance.  of the information printed on this form and will not make any
	Student's signature	Date
		DICAL REPORT
Please note student stu an exam n CEGEP w	e health care professional: e that the student is enrolled in distant dies at their own pace and has six mon to later than three months after their ithin the student's region. Distance ed	nce education studies and can therefore study at home. The oths to complete all of their assignments. They must then write final assignment is marked. Exams are generally held at a ducation students are autonomous and work independently on ge the pace of their studies and to motivate themselves.
Health-rel	ated issue:	

Start date fo	r the student's discontinuation:		
Estimated da	ate of return to studies:		
Does the stu	dent also need to stop working?:		
education pr	rogram? Please explain clearly:	ent the student from studying at their own pace in a distar	ce
Is it a time n	nanagement problem?:		
	HEALTH CARE PR authorized health care professionals a	are allowed to sign this form (signature stamps will be	
Name of the	health care professional (please print	f):	
Permit numl	ber (C.P.M.Q.) :		
Address:	Street		
	City		
	Postal code		
Telephone:			
Sign	ature (do not use a signature stamp)		

Any fees incurred from this report shall be assumed by the student. All incomplete documents will be returned to the student.